EXHIBIT D

UnitedHealthcare

Student Resources
P.O. Box 809025
Dallas, TX 75380-9025
1-800-767-0700

June 04, 2021

Christopher Mcnaughton
229 Woodland Dr.
State Colleg, PA 16803

Insured:	Christopher Mcnaughton
Insured DOB:	06/11/1991
Claim#:	20124734-01
SRID#:	8250035
Policy:	20-3694-01
Legal Entity:	United Healthcare Insurance Company

Dear Christopher McNaughton:

This is to acknowledge your request for consideration of coverage for your medications, J1745-Remicade 20mg/kg every four weeks and J3380-Entyvio 600mg every four weeks for the 2021-2022 policy term.

As previously communicated to you, your medical records were reviewed to determine whether the medication you have been prescribed is medically necessary. The records have been reviewed three times and the medical reviewers have concluded that the medication as prescribed does not meet the Medical Necessity requirement of the plan. In addition, a peer-to-peer review was conducted between your physician and a medical expert representing our company. Our medical representative determined that use of Remicade and Entyvio together is supported in this case. However, it was also determined that the prescribed dosages for the two drugs are not established when using a dual biologic therapy. The concern from the reviewers is the safety of the prescribed dosage and frequency.

In accordance with the conclusions of the reviewers, the two prescribed medications, Remicade and Entyvio, will not be covered at the prescribed dosage under the Penn State Student plan for the 2021-2022 academic year. Please understand that the reviews have been conducted in advance of you enrolling in the 2021-2022 Penn State student plan to give you an opportunity to make an informed decision about your health insurance coverage for the upcoming academic year.

Please note this is not a treatment decision. Treatment decisions are made between you and your physician. This is a denial for benefits under the plan for the prescribed treatment.

An insured person or their authorized representative may have the right to have this decision review by healthcare professionals who have no association with us when the treatment in question:

1. Is a covered medical expense under the policy; and
2. Is not covered because it does not meet the Company's requirements for medical necessity, appropriateness, healthcare setting, level of care, effectiveness or the treatment is determined to be experimental or investigational.

You have the right to have this decision reviewed by an external independent third party who has no association with us. You or your authorized representative, such as a family member or physician, may request this external review as you have exhausted the internal appeal process.

The insured person or their authorized representative has four (4) months to request an external review of

this final determination. The request for an external review should be made in writing to the Company. When filing a request for an external review you will be required to authorize the release of medical records. If requesting an external review, complete and return the enclosed form along with your written request to:

Claims Appeals
UnitedHealthcare Student Resources
P.O. Box 809025
Dallas, Texas 75380-9025

An insured person or their authorized representative may submit a request for an expedited external review if one of the following applies:

- If the insured person has a medical condition where the time-frame for completion of an expedited internal review or a standard external review would seriously jeopardize the life or health, or jeopardize the insured person's ability to regain maximum function.
- If the denial of coverage is based on a determination that the recommended or requested service or treatment is experimental or investigational and the treating physician certifies in writing that any delay may pose an imminent threat to the insured person's health.
- If the denial of coverage involves an admission, availability of care, continued stay, or health care service for an insured person who has received emergency services, but has not been discharged from a facility.

An expedited external review may not be provided for retrospective adverse determinations

There may be other resources available to help understand the appeals process. For questions about appeal rights or an adverse benefit determination, the state department of insurance may be able to assist at:

Pennsylvania Insurance Department
Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
Phone: (717) 787-2317
(877) 881-6388
Website: www.insurance.pa.gov

In addition, and under limited circumstances, a request for an expedited external review may be requested. For details, contact our Customer Service Department at 800-767-0700.

Sincerely,

Lisa Dealy
Manager of Appeals and Reviews
Student Resources

Enclosures: Language Assistance Program (Insured/Member Only)
Non Discrimination Notice (Insured/Member Only)
External Re view Request Form
Pennsylvania Appeal Rights

Cc: Christopher Mcnaughton

LD/Vk

SPANISH (Español): Para obtener asistencia en Español, llame al 1-866-260-2723
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-260-2723.
CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码1-866-260-2723 。
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-260-2723

REQUEST FOR EXTERNAL REVIEW

This External Review Request Form must be filed within four (4) months after you receive a denial of payment on a claim or a request for coverage of a health care service or treatment.

Return Request to:
UnitedHealthcare StudentResources
Attention: Claims Appeals
P.O. Box 809025
Dallas, TX 75380-9025
Phone: 1-800-767-0700

APPLICANT NAME

Applicant Name:

Applicant Address:
Street City State Zip

Applicant is: _____ Insured Person/Patient

_____ Provider

_____ Authorized Representative

INSURED PERSON / PATIENT INFORMATION

Insured Person's Name:

Patient's Name (of other than Insured Person):

Insured Person's Address:
Street City State Zip

Insured Person's Phone Number: (_____) (_____)
Home cell

INSURANCE INFORMATION (from the Insured Person's ID card)

Insurance Company's Name:

Insurance Company's Address:
Street City State Zip

Insurance Company's Phone Number: (_____)

Insured Person's ID Number:

Insurance Claim / Reference Number:

HEALTH CARE PROVIDER INFORMATION (Treating Physician or Health Care Facility)

Name of Health Care Provider:

Address of Health Care Provider:
Street City State Zip

Contact Person: Phone Number: (_____)

Medical Record Number:

REASON FOR INSURANCE COMPANY DENIAL (Please check one)

_____ The health care service or treatment is not medically necessary.

_____ The health care service or treatment is experimental or investigational.

_____ Other:

Summary of External Review Request: Provide a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy ofthe denial from your insurance company.

EXPEDITED REVIEW

If you need a fast decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited appeal? _____ Yes _____ No

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your insurer's denial, you must sign and date this external review request form and consent to the release of medical records.

I, , hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization. I understand that the independent review organization will use this information to make a determination on my external appeal and that the information will be kept confidential and not be release to anyone else. This release is valid for one year.

Signature of Insured Person (or Legal Representative):

Relationship of Legal Representative: Parent Guardian Conservator Other
Specify

APPOINTMENT OF AUTHORIZED REPRESENTATIVE
(Complete this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize to pursue my appeal on my behalf.

Signature of Insured Person (or Legal Representative):

Date Signed:

Authorized Representative's Address:
Street City State Zip

Authorized Representative's Phone Number: Daytime (__) Evening (___)

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

Describe in your own words the disagreement with your Insurance Company. Indicate clearly the service(s) being denied and the specific date(s) being denied. Explain why you disagree. Attach additional page if necessary and include available pertinent medical records, any information you received from your Insurance Company concerning the denial, any pertinent peer literature or clinical studies, and any additional information from your Physician/Health Care Provider that you want the Independent Review Organization reviewer to consider.

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW. (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL Three (3) ITEMS BELOW ARE INCLUDED.)

1. **YES,** I have included this completed application form signed and dated.

2. **YES,** I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the Insurance Company named in this application.

3. **YES,** I have enclosed the letter from my Insurance Company.

Call the Customer Service Department at 800-767-0700 if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English
Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian
Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amharic
የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic
تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian
Ձեզ մատչելի են անվճար լեզվական օգնության ծառայություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

Bantu- Kirundi
Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)
Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangala
ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese
ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

Cambodian- Mon-Khmer
សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

Cherokee
ᏙᎯᏱᏍᏓ ᎤᎾᎵᏍᎦᏗ ᎤᎾᏛᎨᎢ ᏂᎯ ᎡᏣᏛᏔᏍᏓᏁᏱᎢ ᏂᏓᎬᏩᏳᎾ ᎠᏎᏍᎢ. ᎰᏩ ᎠᏂ ᏫᏓᎳᏛᏍ 1-866-260-2723.

Chinese
您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctaw
Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo
Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

Dutch
Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French
Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole- Haitian Creole
Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

German
Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

Greek
Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarati
ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કૉલ કરો.

Hawaiian
Kōkua manuahi ma kāu ʻōlelo i loaʻa ʻia. E kelepona i ka helu 1-866-260-2723.

Hindi
आप के लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong
Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

Ibo
Enyemaka na-ahazi asụsụ, bu n'efu, dịrị gị. Kpọọ 1-866-260-2723.

Ilocano
Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian
Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

Italian
Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese
無料の言語支援サービスをご利用いただけます。1-866-260-2723 までお電話ください。

Karen
ကျိာ်တၢ်မၤစၢၤအဂီၢ်နမၤန့ၢ်အီၤသ့ဝဲလၢတလိာ်ဟ့ဉ်အပှ့ၤဘဉ်(ခီလီ)န့ဉ်လီၤ. ဝံသးစူၤဆဲးကိုးဘဉ်1-866-260-2723တက့ၢ်.

Korean
언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

Kru- Bassa
Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yoŋ. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani
خزمەتەکانی یارمەتیی زمانی بەخۆرایی بۆ تۆ دابین دەکرێن. تکایە تەلەفۆن بکە بۆ ژمارەی 1-866-260-2723.

Laotian
ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

Marathi
भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese
Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjeļọk wōņāān. Jouj im kallọk 1-866-260-2723.

Micronesian- Pohnpeian
Mie sawas en mahsen ong komwi, soh isepe. Melau eker 1-866-260-2723.

Navajo
Saad bee áka'e'eyeed bee áka'nída'wo'ígíí t'áá jíík'eh bee nich'į' bee ná'ahoot'i'. T'áá shǫǫdí kohjį' 1-866-260-2723 hodíilnih.

Nepali
भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गर्नुहोस्।

Nilotic-Dinka
Käk ë kuny ajuɛɛr ë thok atö tïnë yïn abac të cïn wëu yeke thiëëc. Yïn cɔl 1-866-260-2723.

Norwegian
Du kan få gratis språkhjelp. Ring 1-866-260-2723.

Pennsylvania Dutch
Schprooch iwwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

Persian-Farsi
خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 1-866-260-2723 تماس بگیرید.

Polish
Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

Portuguese
Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

Punjabi
ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

Romanian
Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-866-260-2723.

Russian
Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-866-260-2723.

Samoan- Fa'asamoa
O loo maua fesoasoani mo gagana mo oe ma e lē totogia. Faamolemole telefoni le 1-866-260-2723.

Serbo- Croatian
Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

Somali
Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa. Fadlan wac 1-866-260-2723.

Spanish
Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

Sudanic- Fulfulde
E woodi walliinde dow wolde caahu ngam maaɗa. Noodu 1-866-260-2723.

Swahili
Huduma za msaada wa lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

Syriac- Assyrian
ܚܕܡܬܐ ܕܗܝܪܐ ܒܠܫܢܐ، ܡܛܝܒܐ ܐܢܝܢ ܩܕܡܝܟ ܡܓܢܐܝܬ. ܒܒܥܘܬܐ ܩܪܝ ܥܠ ܡܢܝܢܐ 1-866-260-2723.

Tagalog
Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

Telugu
లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి. దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

Thai
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข 1-866-260-2733

Tongan- Fakatonga
'Oku 'i ai pē 'a e sēvesi ki he lea´ ke tokoni kiate koe pea 'oku 'atā ia ma'au 'o 'ikai ha totongi. Kātaki 'o tā ki he 1-866-260-2723.

Trukese (Chuukese)
En mei tongeni angei aninisin emon chon chiakku, ese kamo. Kose mochen kopwe kokkori 1-866-260-2723.

Turkish
Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 numarayı arayınız.

Ukrainian
Послуги перекладу надаються вам безкоштовно. Дзвоніть за номером 1-866-260-2723.

Urdu
زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلامعاوضہ دستیاب ہیں۔ براہ مہربانی 1-866-260-2723 پر کال کریں۔

Vietnamese
Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui lòng gọi 1-866-260-2723.

Yiddish
שפראך הילף סערוויסעס זענען אוועילעבל פאר אייך פריי פון אפצאל. ביטע רופט 1-866-260-2723.

Yoruba
Isẹ́ iránlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.

NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free **1-800-368-1019, 800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

REQUEST FOR EXTERNAL REVIEW

This External Review Request Form must be filed within four (4) months after your receipt of a denial of payment on a claim or a request for coverage of a health care service or treatment.

Return Request to:
UnitedHealthcare StudentResources
Attention: Claims Appeals
P.O. Box 809025
Dallas, TX 75380-9025
Phone: 1-800-767-0700

APPLICANT NAME

Applicant Name: _____

Applicant Address: _____
Street City State Zip

Applicant is: _____ Insured Person/Patient

_____ Provider

_____ Authorized Representative

INSURED PERSON / PATIENT INFORMATION

Insured Person's Name: _____

Patient's Name (of other than Insured Person): _____

Insured Person's Address: _____
Street City State Zip

Insured Person's Phone Number: (____) _____ (____) _____
Home cell

INSURANCE INFORMATION (from the Insured Person's ID card)

Insurance Company's Name: _____

Insurance Company's Address: _____
Street City State Zip

Insurance Company's Phone Number: (____) _____

Insured Person's ID Number: _____

Insurance Claim / Reference Number: _____

HEALTH CARE PROVIDER INFORMATION (Treating Physician or Health Care Facility)

Name of Health Care Provider: _____

Address of Health Care Provider: _____
Street City State Zip

Contact Person: _____ Phone Number: (____) _____

Medical Record Number: _____

REASON FOR INSURANCE COMPANY DENIAL (Please check one)

_____ The health care service or treatment is not medically necessary.

_____ The health care service or treatment is experimental or investigational.

_____ Other:

Summary of External Review Request: Provide a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your insurance company.

_____

_____

_____

_____

EXPEDITED REVIEW

If you need a fast decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited appeal? _____ Yes _____ No

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your insurer's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization. I understand that the independent review organization will use this information to make a determination on my external appeal and that the information will be kept confidential and not be release to anyone else. This release is valid for one year.

Signature of Insured Person (or Legal Representative): _____

Relationship of Legal Representative: ____ Parent ____ Guardian ____ Conservator ____ Other _____
Specify

APPOINTMENT OF AUTHORIZED REPRESENTATIVE
(Complete this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

Signature of Insured Person (or Legal Representative): _____

Date Signed: _____

Authorized Representative's Address: _____
Street City State Zip

Authorized Representative's Phone Number: Daytime (___) _____ Evening (___) _____

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

Describe in your own words the disagreement with your Insurance Company. Indicate clearly the service(s) being denied and the specific date(s) being denied. Explain why you disagree. Attach additional page if necessary and include available pertinent medical records, any information you received from your Insurance Company concerning the denial, any pertinent peer literature or clinical studies, and any additional information from your Physician/Health Care Provider that you want the Independent Review Organization reviewer to consider.

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW. (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL Three (3) ITEMS BELOW ARE INCLUDED.)

1. ____ **YES,** I have included this completed application form signed and dated.

2. ____ **YES,** I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the Insurance Company named in this application.

3. ____ **YES,** I have enclosed the letter from my Insurance Company.

Call the Customer Service Department at 800-767-0700 if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

Explanation of Benefits
Pennsylvania

You or your authorized representative, such as a family member or physician, may request an internal appeal of this determination. The request for an internal appeal must be made within 180 days from the date you receive this statement. Please call our Customer Service Department at 800-767-0700 if you have any questions regarding this determination or to begin the appeal process. Please send your written request for an internal appeal, along with any written comments, documents, records or other material relevant to the claim, to: UnitedHealthcare/StudentResource, PO Box 809025, Dallas TX 75380-9025.

You may also request copies, free of charge, of information relevant to your claim by contacting us at the address shown above.

If you need diagnosis and/or treatment code information related to this claim, please call the number shown on your ID card or the Customer Service Department at the number shown above.

You may request, free of charge, a copy of the internal rule, guideline or protocol, or an explanation of the scientific basis and/or clinical judgment we relied upon in making this decision regarding your claim.

You may have the right to have this decision reviewed by an external independent third party who has no association with us. This external review right is available after the internal appeal process is completed. In addition, and under limited circumstances, a request for an expedited external review may be requested at the same time you submit an internal appeal request. For details, contact our Customer Service Department at 800-767-0700.

There may be other resources available to help you understand the appeals process. For questions about your appeal rights or an adverse benefit determination, the Pennsylvania Department of Insurance may be able to assist you at:

Pennsylvania Department of Insurance
1209 Strawberry Square
Harrisburg, Pennsylvania 17120
(877) 881-6388
www.insurance.pa.gov

SPANISH (Español): Para obtener asistencia en Español, llame al 800-767-0700
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-767-0700.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 800-767-0700.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-767-0700.